PART H

DIVISION V

COMMUNITY SUPPORT PROGRAM (CSP)

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a complex set of regulations known as the Wisconsin Administrative Code, Rules of Health and Social Services, Chapters HSS 101-108 and by state and federal law. These regulations are interpreted for provider use in two parts of the WMAP provider handbook. The two parts of the handbook are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific part of the handbook at the time of certification.

Additional copies of provider handbooks may be purchased by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental). The document number of Part H of the handbook is POH-1050-H.

In addition to handbooks, providers are periodically issued bulletins regarding ongoing policy changes. Providers must maintain and cross reference the bulletins with the handbook as they are received to ensure access to the most current information.

It is important that both the provider of service and the provider's billing personnel read this material prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales at the address indicated above.

Providers should also be aware of other documents including state and federal laws and regulations, relating to the WMAP:

- Chapter 49.43 - 49.497, Wisconsin Statutes
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and their abbreviations appear in Appendix 30 of Part A of the handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

PART H, DIVISION V
COMMUNITY SUPPORT PROGRAM (CSP)
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Each update to Part H, Division V, of the handbook is numbered sequentially. This sequential numbering system alerts the provider to any updates not received. Providers must delete old pages and insert new pages as instructed. Use of this log helps eliminate errors and ensures an up-to-date handbook.

If a provider is missing a transmittal, please request it by transmittal number. For example, if the last transmittal number on your log is 5H-3 and you receive 5H-5, you are missing 5H-4. If a provider is missing a transmittal, copies of complete provider handbooks may be purchased by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Transmittal Number	Initials	Issue Date
5H-1		09/10/90
5H-2		03/92
5H-3		06/92
5H-4		11/92

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A. TYPE OF HANDBOOK

Part H, Division V, Community Support Program (CSP), is the service specific portion of the Wisconsin Medical Assistance Provider Handbook. It is the fifth division of Part H, the Mental Health Handbook, which includes information for all mental health services. Division V includes information for CSP providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, and billing instructions. Division V is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

B. INTRODUCTION

Community Support Program - Purpose

The purpose of Community Support Programs (CSPs) is to provide individuals with chronic (e.g., long term) mental illness with effective and easily accessible treatment, rehabilitation, and support services. CSP services are provided in the community, where recipients live and work, as opposed to in clinics or institutions. It is thought that by helping long-term mentally ill persons better manage the symptoms of their mental illness, fewer institutional placements will be needed.

Community Support Program - Definition

S. HSS 63.029, Wis. Adm. Code defines a CSP as "a coordinated care and treatment program which provides a range of treatment, rehabilitation, and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation, and support services in the community for persons with chronic mental illness."

Chronic mental illness is defined as "a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. Chronic mental illness includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or of alcohol or drug dependence" [s.HSS 63.02(7), Wis. Adm. Code].

C. PROVIDER INFORMATION

Provider Eligibility and Certification

CSP providers are required to be certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS), fulfilling the State regulations set forth in ch. HSS 63, Wis. Adm. Code. The CSP standards became effective May 1, 1989. CSP providers are surveyed on-site every two years by a team of DHSS Division of Community Services surveyors and mental health professionals to ensure that standards continue to be met.

In order to be certifiable by the WMAP, CSP providers must be certified by the DCS under ch. HSS 63, Wis. Adm. Code, and must meet the staffing requirements in s. HSS 63.06, Wis. Adm. Code. In addition, CSP mental health technicians must meet the requirements in s. HSS 105.255, Wis. Adm. Code.

Any CSP whose certification through the DHSS Division of Community Services is terminated, suspended, or denied is not eligible for WMAP certification.

C. PROVIDER INFORMATION (continued)

Mental Health Technician Training and Education Requirements
For WMAP reimbursement, a mental health technician must meet the following training and education requirements:

1. A minimum of 1,000 hours of supervised work experience with the long-term mentally ill.

2. At least one of the following:

   a. Satisfactorily completed the educational curriculum developed by the DHSS; or

   b. Be certified by the American Occupational Therapy Association as an occupational therapy assistant; or

   c. Be a Licensed Practical Nurse (LPN) under s.441.10, Stats.; or

   d. Have satisfied the training requirements under s. HSS 133.17(4) Wis. Adm. Code for a home health aide; or

   e. Be included in the registry of persons under s.HSS 129.10, Wis. Adm. Code, who have completed a nurse's assistant training and testing program or only a testing program; or

   f. Have satisfied the requirements under s.HSS 105.17(3)(a)1. Wis. Adm. Code, to provide personal care services and has completed an additional 1,000 hours of supervised work experience with long-term mentally ill persons.

3. A mental health technician providing CSP services who does not meet the requirements above must meet these requirements within one year following the effective date of the CSP's WMAP certification or the mental health technician's date of employment by the CSP, whichever is later. If this requirement is not met, the CSP may no longer bill for the mental health technician' services. However, the CSP may bill for the mental health technician's services during the one year period.

Application for Certification
For information regarding certification by the Division of Community Services, under ch. HSS 63, Wis. Adm. Code, providers must contact:

CSP Unit
Office of Mental Health
Division of Community Services
Post Office Box 7851
Madison, WI 53707

For information regarding WMAP certification under s. HSS 105.255 Wis. Adm. Code, providers must contact:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

C. PROVIDER INFORMATION (continued)

Billing and Non-Billing Provider Numbers

A provider number is issued to all qualified CSPs certified with the WMAP. The individuals providing service within the CSP do not need to be individually certified.

In most counties, the county 51.42 board is the WMAP certified CSP. In several counties, the 51.42 board contracts with qualified CSPs. In these counties, both the county 51.42 board and the contracted agency must be certified with the WMAP.

When the 51.42 board is the CSP, a billing/performing provider number is issued to the 51.42 board, that number is used to bill the WMAP and no additional provider number is required on the claim form.

In counties where the 51.42 board contracts with qualified CSPs, the 51.42 board is issued a billing provider number and the contracted CSP is issued a non-billing/performing provider number. Both the billing provider number and the non-billing/performing provider number are required on the claim form, but reimbursement is made only to the 51.42 board.

The CSP must bill for Clozapine Management using only the billing provider number. The CSP may use the patient account field (element 26 of the HCFA 1500 claim form) to identify the performing CSP in those counties where there are a number of programs contracting with the county to provide CSP services.

Refer to Appendix 1 in this handbook for instructions on completion of the National HCFA 1500 claim form and the proper use of billing and non-billing provider numbers. Refer to Section II of Part A of the WMAP Provider Handbook for additional information on types of provider numbers.

Scope of Service

The policies in Part H, Division V govern all CSP services provided within the scope of the practice of the profession as defined in s. 49.46(2)(b)6.f, Wis. Stats. and s. HSS 107.13(6), Wis. Adm. Code. Covered services and related limitations are enumerated in Section II of this handbook.

Reimbursement

CSP Services

Reimbursement is made to the county 51.42 board based on a maximum allowable fee per hour for CSP services provided to Medical Assistance recipients. Providers are reimbursed the federal share of the lessor of the maximum allowable fee or the billed amount. The county 51.42 board is responsible for providing the state matching funds for CSP services. This match must come from non-federal funds available to the county. No state General Purpose Revenue (GPR) dollars are allocated to CSPs. Providers are responsible for maintaining an audit trail to document their expenditure and contribution of funds.

Clozapine Management

The WMAP reimburses the CSP a predetermined fee per seven-day period for all allowable Clozapine Management services delivered over the course of one week. CSPs are reimbursed for Clozapine Management only once per seven-day period. All necessary Clozapine Management services, as listed in Section II-G of this handbook, are included in the one weekly payment for Clozapine Management, regardless of the actual number of services provided.

C. PROVIDER INFORMATION (continued)

CSPs receive the full WMAP reimbursement (federal share plus state match) for Clozapine Management services. Counties are not required to provide the non-federal match for these services when they are reimbursed as Clozapine Management.

Reimbursement for Clozapine Management services is made to the county identified as the billing provider. However, the county receives the full share of the Medical Assistance reimbursement for these services. When the county is not the performing provider of the Clozapine Management services, the county must pass through the full payment for the Clozapine Management services to the performing CSP. The county is not responsible for local matching funds for this service.

Provider Responsibilities

Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

D. RECIPIENT INFORMATION

Eligibility For Medical Assistance

Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and an indicator of private health insurance coverage, HMO coverage, and Medicare coverage.

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V-C of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Section V-C of Part A must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V-D of Part A of the Provider Handbook for additional information regarding medical status.

Recipients Eligible for CSP Services

CSP is a benefit for Medical Assistance recipients 18 years of age or over. Recipients enrolled in WMAP-contracted HMOs are not eligible for Medical Assistance CSP services. All eligible recipients must meet the criteria for admission set forth in s. HSS 63.08, Wis Adm. Code.

D. RECIPIENT INFORMATION (continued)

Recipients Enrolled in WMAP-Contracted HMOs

WMAP recipients enrolled in WMAP-contracted HMOs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's HMO. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook. Providers must always check the recipient's current Medical Assistance identification card for HMO coverage before providing services.

WMAP-contracted HMOs do not cover CSP services. However, Medical Assistance recipients who are enrolled, or eligible for enrollment, in a WMAP-contracted HMO and who meet the criteria for admission to a CSP are eligible for disenrollment or exemption from the HMO.

In order for disenrollment to occur, the HMO must submit a disenrollment request to the Bureau of Health Care Financing (BHCF) Contract Monitor that specifies the recipient's name and 10-digit Medical Assistance identification number. This must include a statement from a WMAP-certified medical or mental health provider, or a community support program, indicating eligibility to participate in that program or indicating participation in that program, if it has already begun. This disenrollment will be effective the first day of the month in which participation began or is to begin.

The recipient may ask for an exemption from HMO enrollment, either before or after they are enrolled in an HMO. If the recipient is not yet in an HMO when the exemption is requested, they will be temporarily exempted until the request is either approved or denied. If the recipient is enrolled in an HMO when they apply for exemption, they will remain in the HMO until the month following approval of the exemption.

In order to apply for an exemption from HMO enrollment, the recipient must contact the HMO specialist at their county Department of Social (or Human) Services.

Any services provided to the recipient by CSP providers before the effective date of the HMO exemption or disenrollment are not covered by the HMO or the WMAP. Claims submitted to EDS for these services will be denied.

Copayment

CSP and Clozapine Management services are exempt from recipient copayment.

A. COVERED CSP SERVICES

The CSP services indicated below are covered by the WMAP when prescribed by a physician. All CSP services billed to the WMAP must be identified in the treatment plan except for assessments and treatment planning, case management, and services which must be provided on an emergency basis. The treatment plan must be reviewed and signed by the CSP psychiatrist. Services are reimbursable by the WMAP only if the recipient's treatment plan is written and updated in accordance with the requirements of HSS 63.10(2).

When billing the WMAP, providers may include travel time necessary to provide services away from the CSP office and time spent documenting the services provided.

Telephone contacts are only billable when they involve a crisis intervention or emergency service or when they are specifically identified in the treatment plan as a necessary element of the recipient's treatment. For instance, if identified in the treatment plan, the CSP may bill for calling a recipient in the mornings for the first two weeks of a new job to make sure that the recipient is getting prepared for work and making appropriate plans for traveling to the job.

Each service is reimbursable only if provided by staff allowed to perform that service. Refer to Appendix 7 of this handbook for the qualification descriptions of CSP staff for each level of service. Within each service, separate procedure codes are defined for each of the appropriate levels of staff qualifications. See Appendix 4 of this handbook for a listing of procedure codes and allowable staff for each service. Please refer to Appendix 5 of this handbook for a list of the appropriate place of service codes for each service.

CSP Assessments and Treatment Planning
This service includes:

- Initial assessment
- In-depth assessment
- Treatment plan development and case review to evaluate and revise the current treatment program

The criteria for initial assessment, in-depth assessments, and treatment plans are listed in s. HSS 63.10, Wis. Adm. Code.

The WMAP will only cover services delivered to a recipient after he or she has been formally admitted to the CSP. Only one staff member can bill the WMAP for an assessment, treatment plan, or case review when multiple CSP staff are present.

The referring or prescribing physician must be indicated on all claims submitted for CSP assessment and treatment planning. This may be the CSP's psychiatrist.

CSP Transition to Community Living
Minimal CSP services may be provided to individuals who are inpatients in a hospital or nursing home. However, CSP services are not reimbursable when delivered to individuals 21-64 years of age who are in a hospital or nursing home designated as an institution for mental disease (IMDs). CSP Transition to Community Living procedure codes must be used to bill for any services provided to recipients who are hospital or nursing home inpatients. These services include:

1. Meetings with the recipient during a hospital or nursing home stay to maintain continuity of contact with the CSP treatment team and to evaluate the recipient's progress towards discharge.

A. COVERED CSP SERVICES (continued)

2. Meetings in the hospital or nursing home with the recipient to discuss plans for discharge.

3. Any other covered CSP services (including case management) performed with, or on behalf of, an institutionalized client by qualified CSP staff.

CSP Routine Psychiatric Services
This service includes:

1. Psychiatric evaluations performed by a psychiatrist.

2. Psychological evaluations performed by a psychologist.

3. Individual and family psychotherapy [as defined in s. HSS 101.03(145), Wis. Adm. Code].

CSP Medication Prescription and Administration
This service includes:

1. Prescription of medication related to the psychiatric illness by a psychiatrist.

2. Administration of medication related to the psychiatric illness.

3. Medication checks and evaluation of appropriateness of current medication regimen, including the monitoring of side effects.

4. Administration and assistance in taking other medications if the need for supervision is related to the person's mental illness (e.g., the recipient is not using insulin appropriately).

CSP medication prescription and administration may be billed only by psychiatrists and registered nurses. Medication administration may be billed by psychiatrists or registered nurses. Medication prescription may be billed only by psychiatrists. CSP staff cannot be paid for other medical procedures (e.g., changing dressings on a wound).

CSP Symptom Management or Supportive Psychotherapy
This service includes:

1. Ongoing monitoring of the recipient's mental illness symptoms and response to treatment.

2. Interventions with the recipient to help the recipient identify his or her mental illness symptoms.

3. Teaching of behavioral symptom management techniques to alleviate and manage symptoms not reduced by medication.

4. Assisting the recipient to adapt to and cope with internal and external stresses.

5. Face-to-face crisis intervention, including in-home or community care, to manage a recipient crisis. For example, in order to prevent hospitalization, a recipient who becomes acutely paranoid may need extensive staff supervision over a period of a number of days to ensure that the client does not harm him/herself or others.

6. Time spent in contact with a recipient via a 24-hour crisis line.

A. COVERED CSP SERVICES (continued)

CSP Case Management
This recipient-specific service includes:

1. Coordination efforts to ensure that required assessments, treatment plans, and case reviews involving other CSP staff and community agency staff occur as needed.

2. Coordination, follow up, and monitoring of referrals of the recipient to other community agencies.

3. Coordination of contracting for a specific recipient for specialized services (e.g., Alcohol and Other Drug Abuse [AODA] services which cannot be supplied by CSP staff).

4. Monitoring recipient's symptom status in order to determine the need for additional services or changes in the treatment plan.

5. Contact with other CSP staff which is necessary to ensure that the recipient's treatment plan is being properly implemented and services are coordinated within the program.

6. Coordinating the provision of emergency services during crisis periods. This is distinguished from CSP symptom management and supportive psychotherapy in that these services are not necessarily face-to-face. It is possible that more than one CSP staff may bill for a crisis intervention, with one providing face-to-face contact and one providing case management.

7. Advocating on behalf of the recipient for needed benefits and services other than legal advocacy (e.g., general relief, supplemental security income, housing subsidies, medical services, and food stamps).

8. Coordinating efforts to provide the support, consultation, and educational needs of the recipient's family or others in the support system (including efforts to provide information, education, and support).

The recipient's designated case manager may delegate some of these activities to other appropriate CSP staff. However, CSPs may not bill the WMAP for case management services performed by mental health technicians.

Advocacy or education that is not recipient specific is not covered by the WMAP.

CSP Employment Related Skill Training
This service includes:

1. Initial vocational and educational assessment.

2. Ongoing, on-site vocational assessment/evaluation/feedback sessions to identify symptoms or behaviors and to develop interventions with the recipient and employer that affect work.

3. Individual work-related symptom management.

4. On-the-job or work-related crisis intervention.

A. COVERED CSP SERVICES (continued)

5. Employment-related services, which are not job specific, to assist in gaining and utilizing skills necessary to undertake employment. This includes helping the recipient learn skills related to personal hygiene and grooming, securing appropriate clothing, wake-up services, and on-the-job supportive contacts. In addition, this includes assistance in helping the recipient to learn to arrange transportation.

Covered services are those which address the illness or symptom-related problems that the mental illness creates in securing and keeping a job.

CSP Psychosocial Rehabilitation
This service includes:

1. Individual interventions in social or recreational skill training to improve communication skills and facilitate appropriate interpersonal behavior.

2. Problem solving, support, and supervision related to activities of daily living to assist recipients to gain and utilize skills related to personal hygiene, household tasks, transportation utilization, and money management.

3. Accompanying the recipient to appointments in order to assist in gaining necessary services including:

   - medical and dental care
   - legal services
   - transportation services
   - living accommodation

The CSP may bill the WMAP for accompanying a recipient to an appointment only when:

- the services of a CSP provider are needed in order for the recipient to gain access to the services because of the recipient's psychiatric symptomatology; and

- the need for staff to accompany the recipient is identified in the recipient's treatment plan.

These services differ from CSP case management services since CSP staff will accompany the recipient to appointments for arranging these services (e.g., if a CSP staff member accompanies a recipient to the housing authority).

CSP Group Therapy
This service includes:

1. Psychotherapy groups as performed by a psychiatrist, psychologist, or master's level provider. The goals of the group must be consistent with the definition of psychotherapy in s. HSS 101.03(145), Wis. Adm. Code.

2. Medication education groups provided by an M.D. or R.N. focusing on educating clients about the role of and effects of medications in treating symptoms of mental illness. These groups must not be used solely for the purpose of group prescriptio writing.

3. Employment related groups to focus on symptom management on-the-job, anxiety reduction, and education about appropriate job-related behaviors.

A. COVERED CSP SERVICES (continued)

4. Groups that offer specific skill training in communication, interpersonal skills, or parenting when these groups are identified in the treatment plan for the purpose of improving specific skills which are identified in the assessment as being inadequate.

5. Symptom management groups as performed by an M.D., Ph.D., master's level, or CSP professional. The goals of the group should be consistent with CSP symptom management or supportive psychotherapy.

NOTE: A group is defined as two to ten clients, at least one of whom is a recipient, who are concurrently receiving a service which is identified in this section as group therapy. The service must be specified in the recipient's treatment plan. No more than two CSP staff may bill the WMAP for services provided to the same group of recipients. If two CSP staff bill for recipients in the same group session, they must each bill for different recipients.

B. PLACE OF SERVICE

CSP services may be provided in a variety of settings. All services can be delivered at the CSP office, an outpatient hospital setting, the recipient's home, or other places of service (e.g., recipient's job site, a social security office, grocery store). In addition, transition to community living services may also be delivered at the hospital or nursing home where the recipient is residing. Refer to Appendix 5 of this handbook for a list of the allowable place of service codes for each service.

C. NON-CSP MENTAL HEALTH AND AODA SERVICES

The WMAP does not allow reimbursement for any other outpatient mental health services while a recipient is receiving WMAP reimbursed CSP services. This includes Medical Assistance case management and medical day treatment services. CSPs, as part of their case management function, should monitor the use of other outpatient mental health services by their clients. However, the WMAP allows reimbursement to providers for AODA services provided while a recipient is receiving CSP services.

D. CONTRACTING SERVICES

CSP standards are designed to encourage development of a comprehensive and integrated service delivery system. It is recognized, however, that there may be times when clients have specialized treatment needs that cannot be addressed by the CSP staff. In these cases, the CSP may contract with other qualified providers to deliver services. Contracting is appropriate only for psychiatric or psychotherapy services with a psychologist or Medical Assistance-certifiable psychotherapist in two situations: 1) When the recipient has an established relationship with the independent provider and it would be harmful to the recipient to terminate this relationship; or 2) When the recipient has highly specialized treatment needs (e.g., sexual abuse) which are not required to be provided by the CSP under HSS 63, Wis. Adm. Code. These services must meet the criteria for Routine Psychiatric Services or CSP Medication Prescription and Administration as defined in this section of the handbook. The service must be billed by the CSP.

Psychiatric or psychotherapy services may only be separately billed by non-CSP providers for CSP recipients when they are provided as professional services to recipients who are inpatients in a hospital or nursing home.

When the CSP is contracting with an independent psychotherapy provider, the recipient's medical record must justify the need to contract for the services. The recipient's CSP treatment plan must reflect how these services are integrated with the recipient's overall treatment, including how the independent therapist is involved in treatment planning and review. Additionally, the recipient's record must have copies of progress notes from the independent provider to document the services billed through the CSP. The CSP is responsible for insuring the adequacy and quality of these services.

E. DOCUMENTATION

The recipient's medical record must contain copies of assessments and treatment plans required under HSS 63 and updated according to these standards. The record must have signed and dated notes for all services billed to the WMAP (including those provided by any contracted therapist). The notes must contain sufficient documentation showing that:

- The service provided meets the criteria for the billable services as described in this section;
- The service was provided by the level of professional for which the billing occurred (e.g., CSP professional, Masters);
- The amount of service time reflects the time billed, including any allowed travel time:
- The service is one which is identified in the treatment plan (or is one of the services exempt from this requirement as outlined at the beginning of this section; and
- The service was provided on the billed date.

All notes must be signed by the provider who delivered the service and received reimbursement. For instance, if a CSP professional, a master's level clinical coordinator, and the CSP psychiatrist attended the treatment planning session and the procedure code appropriate for the psychiatrist was billed, then the progress note documenting the meeting must be signed by the psychiatrist, even if another staff member writes the note.

F. NONCOVERED CSP SERVICES

The following services are not covered benefits of the WMAP:

1. CSP services provided to State-contracted HMO enrollees;
2. Recreational therapy (activities which are primarily social or recreational in nature, such as attending a baseball game);
3. CSP services performed by volunteers;
4. Job-specific interventions, job training and job placement services (helping the recipient develop a resume, applying for a job, and job training or coaching);
5. Advocacy which is not client specific;
6. Staff performance of household tasks and chores, such as laundering clothes, housekeeping, and grocery shopping;
7. Time spent "on call" when not delivering services to a client; and
8. Outreach services to potential clients.

G. CLOZAPINE MANAGEMENT SERVICES

Introduction

Clozapine Management is a specialized care management service which may be required to ensure the safety of recipients who are using the psychoactive medication Clozapine. WMAP-certified CSPs may be separately reimbursed by the WMAP for Clozapine Management services provided to Medical Assistance recipients.

G. CLOZAPINE MANAGEMENT SERVICES (continued)

CSPs are not required to bill the care management services for recipients on Clozapine as Clozapine Management. All of the Clozapine Management services described in this section of the handbook may be billed as CSP services when provided and billed in accordance with CSP policy described in Section II-A of this handbook.

For instance, making sure the recipient receives their medication appropriately or discontinues medications if ordered by the physician can be billed as CSP Medication Administration and Management. Making sure that test results are reported to the pharmacy or physician, as appropriate, may be billed as CSP case management. CSPs may bill for these services as CSP services if they are identified in the treatment plan and are provided by allowable staff, as described in Section II-A of this handbook. When these services are billed as CSP services they are not subject to prior authorization. However, the county is reimbursed under the CSP Terms of Reimbursement which means that they receive only the federal share of the allowable reimbursement. When the services are billed as Clozapine Management, the CSP is reimbursed the full contracted rate as described below.

Conditions for Coverage of Clozapine Management
Clozapine Management is covered when all of the following conditions are met:

1. A physician prescribes the Clozapine Management services in writing. Although separate prescriptions are not required for Clozapine and Clozapine Management, the Clozapine Management service must be identified as a separately prescribed service from the drug itself.

2. The recipient is currently taking or has taken Clozapine within the past four weeks.

3. The recipient resides in a community-based (non-hospital or nursing home) setting.

4. The pharmacy dispensing Clozapine obtains prior authorization from the WMAP for reimbursement for Clozapine.

5. The CSP obtains prior authorization for Clozapine Management from the WMAP.

Refer to Section III of this handbook for information on prior authorization for Clozapine Management and to Section IV for billing information.

Components of Clozapine Management Services
The following components are part of the Clozapine Management service:

1. Ensure that the recipient has the required weekly white blood count testing. The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. The provider may travel to the recipient's residence, or other places in the community where the recipient is available, to perform this service, if necessary.

   The provider's transportation to and from the recipient's home or other community location to carry out any of the required services listed here are considered part of the weekly capitation payment for Clozapine Management.

2. Ensure that the blood test results are reported to the pharmacy dispensing the recipient's Clozapine in a timely fashion.

G. CLOZAPINE MANAGEMENT SERVICES (continued)

3. Ensure that abnormal blood test results are reported to the physician who prescribed the recipient's Clozapine.

4. Ensure that the recipient receives medications as scheduled, ensure that the recipient stops taking medication when blood test is abnormal, if so ordered by the physician, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being are maintained.

5. Make arrangements for the transition and coordination of the use of Clozapine and Clozapine Management services between different care locations.

6. Maintain records as described below.

Recordkeeping Requirements for Clozapine Management
The Clozapine Management records must be kept with the recipient's CSP record and must be clearly identified. This record must contain:

1. A face sheet identifying the recipient, to include the following information:

   - recipient's Medical Assistance identification number;
   - recipient's name;
   - recipient's current address;
   - recipient's psychiatric diagnosis;
   - name, address and telephone number of the physician prescribing Clozapine;
   - name, address and telephone number of the primary medical provider (if different than the prescribing physician);
   - name, address and telephone number of the pharmacy from which the recipient is receiving Clozapine;
   - address and telephone number of other locations at which the client may be receiving blood draw and at which the client may be located on a regular basis.

   The CSP face sheet may be used for this purpose if it contains all the information specified.

2. The CSP treatment plan must have a separate problem part indicating the manner in which the provider ensures that the covered services are provided (e.g., the plan indicates where and when blood will be drawn, whether the recipient will pick up medications at the pharmacy or whether they will be delivered by the provider). The plan should also specify signs or symptoms that might be associated with medical conditions resulting from side effects of the drug, or other signs or symptoms related to the recipient's mental illness, which should be reported to a qualified medical professional. The plan should indicate health care professionals responsible for oversight of the Clozapine Management services and indicate how often they will see the recipient. The plan should be reviewed every six months in accordance with the usual standards for CSPs.

3. Copies of all prior authorization requests for Clozapine and Clozapine Management.

G. CLOZAPINE MANAGEMENT SERVICES (continued)

4. Copies of physician's prescriptions for Clozapine and Clozapine Management.

5. Copies of laboratory results of white blood cell counts.

6. Signed and dated notes documenting all Clozapine Management services. The date of all blood draws should be indicated as well as who performed the blood draw. If the provider had to travel to provide services, the travel time should be indicated. Services provided to ensure that recipient received medically necessary care following an abnormal white blood cell count must be documented. The CSP should document the Clozapine Management services in the CSP record chronologically along with documentation of other CSP services. The Clozapine Management notes should be highlighted in a manner which makes them easily identifiable (i.e., a hand stamp).

H. NONCOVERED CLOZAPINE MANAGEMENT SERVICES

The following are not covered as Clozapine Management services:

1. Clozapine Management for recipients not authorized by the WMAP to receive Clozapine.

2. Clozapine Management which has not been prior authorized.

3. Clozapine Management for recipients residing in a nursing home or hospital on the date of service.

4. Care coordination, medical services or provider transportation not related to the recipient's use of Clozapine.

5. Recipient transportation costs to receive any WMAP reimbursed services. Recipient transportation to a physician's office or pharmacy is reimbursed in accordance with sec. HSS 107.23, Wis. Adm. Code. Such transportation, when provided by a specialized medical vehicle, is not covered unless the recipient has a disability which requires personal assistance in ambulating or the use of mechanical aids, such as a wheelchair or crutches. Recipient transportation by common carrier must be approved and paid for by the county agency responsible for Medical Assistance transportation services.

6. The performance of the white blood cell count. The white blood cell count must be performed and billed by a WMAP-certified laboratory in order to be reimbursed by the WMAP.

I. CLOZAPINE MANAGEMENT VERSUS CSP SERVICES

CSPs which provide Clozapine Management services must be extremely careful not to double bill the WMAP for services. This may happen when the CSP provides Clozapine Management services during the same encounter as when they provide WMAP allowable CSP services. In these cases, the CSP must document the amount of time that was spent on the CSP billable service separate from the time spent on the Clozapine Management service.

If the CSP staff travels to the recipient's home to perform Clozapine Management related services (e.g., transport the recipient to receive their weekly blood draw or draw the blood for the weekly white blood cell count), the CSP may <u>not</u> bill the WMAP for CSP-related travel time even if the CSP staff performed other CSP billable services during this visit (i.e., adult daily living skill training). In these cases, reimbursement for travel time is assumed to be included in the weekly reimbursement for Clozapine Management.

I. CLOZAPINE MANAGEMENT VERSUS CSP SERVICES (continued)

Ensuring that the recipient takes Clozapine as scheduled is also considered a Clozapine Management function and, therefore, should not be billable as a CSP service. Regular psychiatric medication management visits which are not exclusively related to Clozapine are not considered a part of the Clozapine Management service and may, therefore, be billed as a CSP service. CSPs are advised to make sure that coordination functions related to Clozapine Management are not billed as CSP case management. Although CSPs must not bill Clozapine Management related services as CSP services, these services must still be identified in the recipient's treatment plan.

A. CSP SERVICES

Community Support Program (CSP) services do not require prior authorization and do not count towards the $500/15 hour prior authorization threshold for mental health and Alcohol and Other Drug Abuse (AODA) services.

B. CLOZAPINE MANAGEMENT SERVICES

Requesting Prior Authorization for Clozapine Management
All Clozapine Management services must be prior authorized by the WMAP. The same Prior Authorization Clozapine Attachment (PA/CZA) may be used for requesting prior authorization for both Clozapine and Clozapine Management.

The CSP requesting Clozapine Management must obtain a copy of the PA/CZA which was used in requesting prior authorization for Clozapine and attach this to a Prior Authorization Request Form (PA/RF) for Clozapine Management. The prior authorization requests for Clozapine and Clozapine Management should be submitted together to EDS. A sample PA/RF for Clozapine Management is found in Appendix 9 of this handbook. Prescription orders dated within two months must accompany prior authorization requests.

Refer to Appendix 11 of this handbook for a sample PA/CZA, and to Appendix 10 for PA/CZA completion instructions.

Authorization Criteria
Clozapine Management is approved when requested if the recipient is approved for use of the drug and the recipient does not reside in a nursing facility. Clozapine is deemed appropriate for an individual with an ICD-9-CM diagnosis of 295.10-295.95, who has a documented history of failure of at least two psychotropic drugs. Lithium Carbonate should not be considered one of the two failed drugs. Failure includes:

- no improvement in functioning level;
- continuation of positive symptoms (hallucinations or delusions);
- severe side effects;
- tardive dyskinesia/dystonia.

The provider must fully complete the PA/CZA. Authorization is for a period of up to six months.

A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under third party insurance, the WMAP reimburses that portion of the allowable cost remaining after all other third party sources have been exhausted. Refer to Section IX-D of Part A of the WMAP Provider Handbook for more detailed information on services requiring third party billing, exceptions, and the "Other Insurance Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing the WMAP. However, Community Support Programs (CSPs) are not a Medicare-covered service, and thus billing Medicare for dual entitlees is not required. A Medicare disclaimer code must be indicated on the claim if the recipient's Medical Assistance identification card indicates Medicare coverage. Refer to Appendix 1 of this handbook for detailed claim form instructions.

C. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charges for the actual number of hours of services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. Providers who do not have a usual and customary charge must bill the WMAP the estimated cost for services provided.

For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient.

Providers should refer to Appendix 1 of this handbook for complete billing instructions.

D. BILLING INCREMENTS

The CSP should bill in hourly units. CSPs may bill in one-tenth hour increments or round to the nearest half hour.

When a CSP is rounding to the nearest half hour and provides more than one service to a Medical Assistance recipient during a single encounter, the provider may bill for the total time, coding each 1/2 hour increment according to the service provided. If the time spent on various services provided are in less than 1/2 hour increments, the provider should bill the entire time to the service which is predominant.

Example: If a CSP professional spends one hour with a client, 1/2 hour of which is psychosocial rehabilitation and 1/2 hour of which is symptom management, the provider should bill as follows:

.5 Psychosocial rehabilitation (procedure code W8273)
.5 Symptom management (procedure code W8243)

Example: If a CSP professional spends 1/2 hour with a client, of which 10 minutes is employment related skill training, 15 minutes is psychosocial rehabilitation, and 5 minutes is symptom management, the provider should bill as follows:

.5 Psychosocial rehabilitation (procedure code W8273)

If a provider bills in one-tenth hour increments, each procedure should be billed separately.

E. CLOZAPINE MANAGEMENT

Providers must bill a quantity of "1" in element 24G of the HCFA 1500 claim form for each week of Clozapine Management services, regardless of the actual number of services provided. All claims for Clozapine Management must have the prior authorization number indicated in element 23 of the HCFA 1500 claim form. The date of service indicated in element 24a must be the last day of the calendar week on which service was actually provided.

F. CLAIM SUBMISSION

Paper Claim Submission

CSP and Clozapine Management services must be submitted using the National HCFA 1500 claim form. Sample claim forms and completion instructions can be found in Appendices 1 and 2 of this handbook.

CSP and Clozapine Management services submitted on any other form than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can reduce their claim submission errors. Free software and consultation services are provided. Additional information on alternative claim submission is available by contacting:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. Claims for coinsurance and deductible for services rendered to recipients covered by both Medicare and Medical Assistance must be received by EDS within 365 days from the date of service, *or* within 90 days from the Medicare EOMB date, whichever is later. (Refer to Section IX of Part A of the WMAP Provider Handbook for exceptions to the 90-day extension.) This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

G. DIAGNOSIS CODES

All CSP claims must have a primary diagnosis of one of the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) codes listed in Appendix 3 of this handbook. Claims received without an allowable ICD-9-CM code as the primary diagnosis are denied.

The complete ICD-9-CM code book can be ordered from:

ICD-9-CM
Post Office Box 991
Ann Arbor, MI 48106

H. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all CSP claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for CSP are included in Appendix 4 of this handbook.

I. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures

SECTION V
COMMUNITY SUPPORT PROGRAM (CSP)
APPENDICES

APPENDIX 1
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR COMMUNITY SUPPORT PROGRAM (CSP) SERVICES
(For Claims Received on or after January 4, 1993)

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - **Program Block/Claim Sort Indicator**
Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) If the recipient has Medicare coverage, enter the Medicare disclaimer code "M-8" since CSP is not a Medicare benefit.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. The first diagnosis listed is the primary diagnosis and must be one of the allowable diagnosis codes listed in Appendix 3 of this handbook. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION (not required)

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)

- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 5 of this handbook for allowable place of service codes.

ELEMENT 24C - TYPE OF SERVICE CODE
Enter "1" as the type of service code.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code. Refer to Appendix 4 of this handbook for a list of allowable procedure codes.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed. All CSP services are one-hour procedure codes. When billing for fractions of an hour, units of service are indicated in either half-hour or one-tenth hour increments, using the rounding guidelines in Appendix 6 of this handbook.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

In counties where the 51.42 board contracts with a qualified CSP, enter the eight-digit non-billing/performing provider number of the contracted CSP. Refer to Appendix 2b of this handbook for a sample claim form of this type.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 2a
THE 51.42 BOARD IS THE CSP

HEALTH INSURANCE CLAIM FORM

PICA

1 MEDICARE (Medicare #) | MEDICAID (Medicaid #) T | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3 PATIENT'S BIRTH DATE MM DD YY | SEX: M X F

4 INSURED'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No., Street): 609 Willow

6 PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7 INSURED'S ADDRESS (No., Street)

CITY: Anytown | STATE: WI

8 PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-D

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: M-8

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 295.6
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 06 92		3	1	W8253		1	XX XX	1.0				
2 01 10 92		3	1	W8220		1	XX XX	0.5				
3 01 14 92	21 28	4	1	W8274		1	XX XX	4.5				
4												
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER | SSN | EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $

30. BALANCE DUE: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M.Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M.Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 2b
THE 51.42 BOARD CONTRACTS WITH A QUALIFIED CSP

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID [P] (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
							0987654321		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Recipient, Im A.			MM DD YY	M [ ] F [X]					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
609 Willow			Self [ ] Spouse [ ] Child [ ] Other [ ]						
CITY		STATE	8. PATIENT STATUS				CITY		STATE
Anytown		WI	Single [ ] Married [ ] Other [ ]						
ZIP CODE	TELEPHONE (Include Area Code)		Employed [ ] Full-Time Student [ ] Part-Time Student [ ]				ZIP CODE	TELEPHONE (INCLUDE AREA CODE)	
555555	(XXX)XXX-XXXX							( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
OI-D							M-8		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]	
			[ ] YES [ ] NO						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]		b. AUTO ACCIDENT?	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
			[ ] YES [ ] NO						
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			[ ] YES [ ] NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							[ ] YES [ ] NO If yes, return to and complete item 9 a-d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
I.M. Referring	12345678	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. 295.6 2. 3. 4.		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 06 92		3	1	W8202		1	XX XX	1.0				11223344
2 01 08 92		3	1	W8253		1	XX XX	1.0				11223344
3 01 10 92		3	1	W8220		1	XX XX	0.5				11223344
4 01 14 92	21 28	4	1	W8274		1	XX XX	4.5				11223344
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
[ ] [ ]	1234JED	[ ] YES [ ] NO	$ XXX XX	$	$ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M.Provider MM/DD/YY		I.M.Billing 100 W. Williams Anytown, WI 55555 87654321
SIGNED DATE		PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 3

WMAP ALLOWABLE CSP DIAGNOSIS CODES

Schizophrenic Disorders:	295.10 - 295.15 295.20 - 295.25 295.30 - 295.35 295.60 - 295.65 295.90 - 295.95
Schizoaffective Disorder:	295.70 - 295.75
Affective Psychoses:	296.20 - 296.26 296.30 - 296.36 296.40 - 296.46 296.50 - 296.56 296.60 - 296.66 296.7 311
Delusional Disorder N.O.S.:	297.1
Psychotic Disorder N.O.S.:	298.9
Autistic Disorders:	299.00 - 299.01
Neurotic Disorders:	300.01 300.11 300.14 300.16 300.19 300.21 300.3 300.4 300.81
Personality Disorders:	301.0 301.22 301.50 301.51 301.6 301.81 301.82 301.83 301.84 301.9
Anorexia Nervosa:	307.1
Tourette's Disorder:	307.23
Intermittent Explosive Disorder:	312.34

APPENDIX 4
WMAP ALLOWABLE PROCEDURE CODES FOR CSP

Procedure Code	Description
W8200	CSP Assessment & Treatment Planning - M.D.
W8201	CSP Assessment & Treatment Planning - Ph.D.
W8202	CSP Assessment & Treatment Planning - Master
W8203	CSP Assessment & Treatment Planning - Professional
W8210	CSP Transition to Community Living - M.D.
W8211	CSP Transition to Community Living - Ph.D.
W8212	CSP Transition to Community Living - Master
W8213	CSP Transition to Community Living - Professional
W8220	CSP Routine Psychiatric Services - M.D.
W8221	CSP Routine Psychiatric Services - Ph.D.
W8222	CSP Routine Psychiatric Services - Master
W8230	CSP Medication Prescription & Administration - M.D.
W8233	CSP Medication Prescription & Administration - Professional (R.N. only)
W8240	CSP Symptom Management & Supportive Psychotherapy - M.D.
W8241	CSP Symptom Management & Supportive Psychotherapy - Ph.D.
W8242	CSP Symptom Management & Supportive Psychotherapy - Master
W8243	CSP Symptom Management & Supportive Psychotherapy - Professional
W8250	CSP Case Management - M.D.
W8251	CSP Case Management - Ph.D.
W8252	CSP Case Management - Master
W8253	CSP Case Management - Professional
W8262	CSP Employment Related Skill Training - Master
W8263	CSP Employment Related Skill Training - Professional
W8271	CSP Psychosocial Rehabilitation - Ph.D.
W8272	CSP Psychosocial Rehabilitation - Master
W8273	CSP Psychosocial Rehabilitation - Professional
W8274	CSP Psychosocial Rehabilitation - Technician
W8280	CSP Group Therapy - M.D.
W8281	CSP Group Therapy - Ph.D.
W8282	CSP Group Therapy - Master
W8283	CSP Group Therapy - Professional
W8901	Clozapine Management

APPENDIX 5

WMAP ALLOWABLE CSP PLACE OF SERVICE CODES

For all procedure codes the following place of service codes are allowable:

POS	Description
0	Other*
2	Outpatient Hospital
3	Office
4	Home

For procedure codes W8210-W8213 (CSP Transition to Community Living), the following additional place of service codes are allowable:

POS	Description
1	Inpatient Hospital
7	Nursing Home
8	Skilled Nursing Facility

* It is not necessary to identify the actual place of service when place of service "0" is used. This code is used for locations not listed below.

APPENDIX 6

ROUNDING GUIDELINES

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s).

Billing in Half-Hour Increments:

Time (in minutes)	Unit(s) Billed
1 - 30	.5
31 - 44	.5
45 - 60	1.0
61 - 74	1.0
75 - 90	1.5
91 - 104	1.5
105 - 120	2.0
121 - 134	2.0
etc.	

Billing in One-Tenth Hour Increments:

Time (in minutes)	Unit(s) Billed
1 - 6	.1
7 - 12	.2
13 - 18	.3
19 - 24	.4
25 - 30	.5
31 - 36	.6
37 - 42	.7
43 - 48	.8
49 - 54	.9
55 - 60	1.0
etc.	

APPENDIX 7

STAFF QUALIFICATIONS FOR CSP BILLING LEVELS

The Wisconsin Medical Assistance Program (WMAP) defines five billing levels for CSP staff. This appendix defines the level at which staff should bill based on their qualifications as listed in the CSP Administrative Code, HSS 63.06(2) and 63.06(4)(a).

M.D. . . . . . A psychiatrist who is a physician licensed under ch. 448, Stats., who has satisfactorily completed three years residency training in psychiatry in a program approved by the American Medical Association.

Ph.D. . . . . . A clinical psychologist licensed under ch. 455, Stats.

Masters . . . . . A person with a master's degree in social work, clinical psychology, or psychiatric mental health nursing, or equivalent requirements and having either 3,000 hours of supervised clinical experience in a practice where the majority of clients are adults with chronic mental illness or 1,500 hours of supervised clinical experience in a CSP.

CSP Professional . . . . . 1. A person with a bachelor's degree in a behavioral science or a related field with 1,000 hours of supervised post-degree experience with chronically mentally ill persons.

2. A person with a bachelor's degree in a field other than behavioral sciences with 2,000 hours of supervised post-degree experience with persons with chronic mental illness.

3. A registered nurse who holds a current certificate of registration under ch. 441, Stats., and who has experience or education related to the responsibilities of his or her position.

4. A person with a master's degree from a graduate school of social work accredited by the Council on Social Work Education, or a master's degree in a related field.

5. An occupational therapist or recreational therapist with a bachelor's degree in their respective profession.

6. A rehabilitation counselor who is certified or eligible to be certified by the commission on rehabilitation counselor certification.

7. A vocational counselor who shall possess or be eligible for a provisional school counselor certificate and who has a master's degree in counseling and guidance.

Mental Health Technician . . . . . A person who meets the requirements as defined in HSS 105.255 Wis. Adm. Code and reprinted on page 5H1-002 of this handbook.

APPENDIX 8
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR COMMUNITY SUPPORT PROGRAMS

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. Prior Authorization requests will be returned without adjudication if no processing type is indicated.

138 - Clozapine Management Services

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. ***No other information should be entered in this element since it also serves as a return mailing label.***

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service requested.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service requested, in this element.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Appendix 5 of this handbook for a list of allowable place of service codes for CSPs.

ELEMENT 17 - TYPE OF SERVICE
Enter type of service code "1" for each service requested.

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (i.e., number of services) requested for each service.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service requested. If the quantity is greater than "1", multiply the quantity by the charge for each service requested. Enter that total amount in this element.

> *NOTE:*
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with WMAP payment methodology and policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER - - THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 9
PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 138

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
Anytown CSP
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 295.70 Schizo-affective disorder

11 DX: SECONDARY:

12 START DATE OF SOI: N/A

13 FIRST DATE RX: N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8901		4	1	Clozapine Management	26	X,XXX.XX
					TOTAL CHARGE	21 X,XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 C.S.P. Psychiatrist, M.D. (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

APPENDIX 10
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION CLOZAPINE ATTACHMENT (PA/CZA)

The information contained on this prior authorization clozapine attachment will be used to make a decision about appropriateness and length of time which will be approved for Medical Assistance reimbursement. Please complete each section as completely as possible and include any material which you believe will be of help in understanding the necessity for the services you are requesting. Where noted in these instructions, you may substitute material which you may have in your records for the information requested on the form. The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted. Complete this attachment form, attach it to the Prior Authorization Request Form (PA/RF) and submit to the following address:

EDS
Prior Authorization Unit
6406 Bridge Road, Suite 88
Madison, WI 53784-0088

Questions regarding the completion of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Clozapine Attachment (PA/CZA) may be addressed to EDS' Telephone/Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S AGE
Enter the age of the recipient in years (e.g., 45, 60, 21, etc.).

PROVIDER INFORMATION:

ELEMENT 6 - PRESCRIBING PHYSICIAN NAME
Enter the name of the physician who is prescribing the Clozapine. The prescribing physician is that physician who is treating the patient.

ELEMENT 7 - PRESCRIBING PHYSICIAN NUMBER
Enter the nine-character DEA number of the prescribing physician.

ELEMENT 8 - PRESCRIBING PHYSICIAN TELEPHONE NUMBER
Enter the telephone number, including area code, of the prescribing physician.

DOCUMENTATION:

Copies of written and signed documentation may be substituted only if they provide the same information as that requested on the PA/CZA and are dated within two months of receipt at EDS.

Section I

1. Must be completed by a physician. Indicate diagnoses by code and description on all five axes from the current DSM.

2. On the initial request, this information should be historical and include justification for Clozapine treatment. Provider may attach copies of evaluations, treatment history, etc., if they support all the information requested, but these copies should not substitute for brief summary requested.

   On subsequent requests, it should be information updated since the previous request.

Section II
Previous Neuroleptic Medication should include all neuroleptic medication used during the past 10 years, or longer if the failed treatment occurred more than 10 years ago. Since Clozapine is recommended only after the failure of at least two neuroleptic medications, this section must be completed on the initial request. It must document the failures of two neuroleptic medications. This area does not need to be completed on subsequent requests. (Attach additional pages if necessary.)

Section III
Include hospital days for psychiatric disorders within the past six months, three years, and five years on the initial request. Include updated information on subsequent requests.

Record the number of hospitalizations that preceded those listed above.

Section IV Brief Psychiatric Rating Scale (BPRS)
Please complete the 24-point Brief Psychiatric Rating Scale (BPRS). The BPRS must be done in person by a clinician trained to assess mental status and must be dated within two months of receipt at EDS.

Section V
Document the prescribing physician's qualifications for prescribing neuroleptic medication. This area does not need to be completed on subsequent requests if the prescriber does not change. Papers showing credentials may be substituted.

Prescription
Attach a copy of the physician's prescription to the form. The prescription must be signed and dated within two months of receipt at EDS and should be of standard format (e.g., dosage and duration.)

Signature
The form must be dated and signed by the prescribing (treating) physician.

Section VI Additional Information
The information requested below is not used in adjudicating the prior authorization but is required for a long-term study of Clozapine. All information must be supplied on each request.

A. Social Status

   Please complete questions 1 through 6.

B. Medication Administration - Please answer questions 1 through 3. While these functions are the responsibility of the prescribing physician, this information offers some assurance that the management recommended by the manufacturer is being followed.

C. Current Medications - The list should include all drugs the patient is using currently or has used during the past month. A medication order record may be substituted.

D. Non-Medical Treatment - On the initial request, describe non-medical services the individual has received. Update information as necessary on subsequent requests.

APPENDIX 11
PRIOR AUTHORIZATION CLOZAPINE ATTACHMENT (PA/CZA) SAMPLE

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/CZA
PRIOR AUTHORIZATION
CLOZAPINE ATTACHMENT

1. Complete this form
2. Attach to PA/RF
   (Prior Authorization Request Form)
3. Mail to E.D.S.

RECIPIENT INFORMATION

(1)	(2)	(3)	(4)	(5)
Recipient	Im	A	1234567890	26
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

(6)	(7)	(8)
I. M. Prescribing	xxxxxxxxx	(xxx) xxx - xxxx
PRESCRIBING PHYSICIAN'S NAME	PRESCRIBING PHYSICIAN'S DEA NUMBER	PRESCRIBING PHYSICIAN'S TELEPHONE NUMBER

SECTION I Diagnostic Information

1. Please give a current diagnostic statement for this patient including all 5 axes from current DSM manual.

Axis I: 295.70 Schizo - Affective disorder

Axis II: None

Axis III: None

Axis IV: Five-serious chronic illness

Axis V: 35

2. Description of patient's illness

Include onset and intensity of psychosis, current and past treatment history other than hospitalizations, symptom management and psychotherapy. Describe rationale for use, or continuing use, of clozapine.

Since 18 years of age, she has suffered from auditory hallucinations, paranoid delusions and manic episodes. Attends a community support program and has also participated in day treatment program. Clozapine is indicated because other neuroleptic medications have not alleviated symptoms.

SECTION II Previous Neuroleptic Medications

Previous Neuroleptic Medication (within past 10 years or longer if failures of medication occurred before that time)
(Not necessary on subsequent requests)

Drug name	Highest Daily Dosage	Date Start/End	Side Effects and/or Reason Discontinued
Haldol and Haldol Decanoate	30 mg PO 100 mg q 2wks	8/88 to Present	Remains on but continues to have delusions and hallucinations
Prolixin and Prolixin Decanoate	20 mg PO 50 mg q 2wks	7/87 to 7/88	No relief from hallucinations and delusions
Thorazine	500 mg	2/85 to 7/87	No relief from hallucinations and delusions

SECTION III Hospitalizations

1. Hospital days for psychiatric disorder within the past six months 13.
2. Hospital days for psychiatric disorder within the past three years 62.
3. Hospital days for psychiatric disorder within the past five years 150.
4. Number of hospitalizations for psychiatric disorder prior to last five years 10.

SECTION IV Brief Psychiatric Rating Scale (BPRS)

DATE ADMINISTERED: MM/DD/YY

The following 24-item version must be completed in person and must reflect the patient's current condition. Enter the number on the line using the scale value below that best describes the patient's present condition.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
No problem	Very mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe

1. 4 Somatic Concern - preoccupation with physical health, fear of physical illness, hypochondriasis
2. 7 Anxiety - worry, fear, overconcern for present or future
3. 5 Depressive mood - sorrow, sadness, despondency, pessimism
4. 4 Guilt feelings - self-blame, shame, remorse for past behavior
5. 6 Hostility - animosity, contempt, belligerence, disdain for others
6. 7 Suspiciousness - mistrust, belief others harbor malicious or discriminatory intent
7. 5 Unusual thought content - unusual, odd, strange, bizarre thought content
8. 2 Grandiosity - exaggerated self-opinion, arrogance, conviction of unusual power or abilities
9. 7 Hallucinatory behavior - perceptions without normal external stimulus correspondence
10. 7 Emotional withdrawal - lack of spontaneous interaction, isolation, deficiency in relating to others
11. 3 Suicidality - expressed desire, intent, or actual actions to harm or kill self
12. 6 Self - Neglect - hygiene, appearance, or eating below social standards
13. 1 Disorientation - confusion regarding person, place or time
14. 6 Conceptual Disorganization - thought process confused, disconnected, disorganized, disrupted
15. 6 Excitement - heightened emotional tone, increased reactivity, impulsivity
16. 2 Motor Retardation - slowed, weakened movements or speech, reduced body tone
17. 2 Blunted Affect - reduced emotional tone, reduction in normal intensity of feelings, flatness
18. 7 Tension - physical and motor manifestations or nervousness, hyperactivity
19. 4 Mannerisms and Posturing - peculiar, bizarre unnatural motor behavior
20. 6 Uncooperativeness - resistance, guardedness, rejection of authority
21. 1 Bizarre Behavior - reports of odd, unusual or psychotically criminal behavior
22. 4 Elated Mood - euphoria, optimism that is out of proportion to circumstances
23. 7 Motor Hyperactivity - frequent movements and/or rapid speech
24. 6 Distractability - speech and actions interrupted by minor external stimuli or hallucinations and delusions

TOTAL: 115

SECTION V Prescribing (treating) Physician's Credentials

1. Are you a Board Certified or Board Eligible psychiatrist? Yes [X] No [ ]

2. If prescriber is not a psychiatrist, please provide documentation describing credentials as experienced in using neuroleptic drugs in clinical practice.

Attach a copy of the physician's prescription for clozapine. The prescription must be signed and dated and must cover the period of time being requested.

AUTHORIZATION IS GIVEN BASED ON INFORMATION SUBMITTED. RESPONSIBILITY FOR ASSESSING THE ADVISABILITY OF PRESCRIBING CLOZAPINE AND FOR ASSURING COMPLIANCE WITH ANY REQUIRED MONITORING LIES WITH THE PRESCRIBING PHYSICIAN.

04/15/92
DATE

I. m. Prescribing, m.D.
TREATING/PRESCRIBING PHYSICIAN

Recipient Name Im A. Recipient
Recipient MA ID # 1234567890

SECTION VI Additional Information

The information requested below is not used in adjudicating the prior authorization, but is required for a long-term study of clozapine.

A. Social Status

1. Legal guardianship and/or informal responsibility (check all that apply)

- [ ] Legal guardian established
- [ ] Spouse responsible
- [ ] Other legal oversight
- [ ] Other relative responsible
- [X] Resident/self responsible

2. Marital status (check one)

- [X] Single
- [ ] Separated
- [ ] Married
- [ ] Divorced
- [ ] Widowed

3. Current financial support other than SSI? Yes [ ] No [X]

4. Is patient currently employed? Yes [ ] No [X]

Paid job Yes [ ] No [ ] Type of work _____

# of hours per week _____ How long in position? _____

5. Is patient currently in school? Yes [ ] No [X]

If Yes, please check type of schooling:

- [ ] High School/GED
- [ ] Vocational
- [ ] College/University

6. Living situation. Please check one.

- [X] Private home/apartment/condo
- [ ] Retirement home
- [ ] Private room/rooming house
- [ ] Nursing home
- [ ] Homeless
- [ ] Other _____
- [ ] DOM/board and care home/group home/group residence

B. Medication Administration

1. Who is responsible for drawing blood for WBC? CSP coordinates it.
2. Who is responsible for reporting WBC results to physician/pharmacist? Lab
3. Who is responsible for overseeing clozapine administration? CSP staff.

C. Current Medications

Please list all known drugs presently taken by this patient. Include all drugs prescribed or used during the past month and the use of PRNs and over the counter medications.

Drug Name	Dosage Instructions/ Frequency	Date Started	Side Effects
Lithium CO_3	600 mg BID	3/88	Dry mouth
Lorazepam	2 mg PRN	4/89	None
Haldol	30 mg HS	8/88	None
Haldol Dec	100 mg lm q 2 weeks	8/88	None

D. Non-medical Treatment (continue on back)

Psychosocial and rehabilitation services, adequacy of community support, family involvement, CSP programming, etc.

Daily contact with CSP staff. Brother is very attentive, supportive. Lives with male friend who is supportive, calls CSP staff when she isn't doing well.